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Secure Attachment Without Bars: Alternatives to Incarceration and Clinical Interventions to Treat the Mother-Infant Relationship

Krista M. Murphy, B. S.

MSW Clinical Research Paper

Presented to the Faculty of the School of Social Work at
St. Catherine University and the University of St. Thomas in St. Paul, Minnesota in
Partial Fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University - University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Between 1980 and 2011, the number of incarcerated women increased by more than 700% (The Sentencing Project, 2017; 2015). Since *The Second Chance Act* was passed in 2008, the women's prison population has grown outpacing men's, grown while men's declined, or declined proportionally less than men's in seventy-percent of states, according to the Prison Policy Initiative (Sawyer, 2018). This paper explores the reasons for this disproportionate growth by outlining public policy developments and pathways women take to incarceration that are intertwined with trauma, mental health, and substance use in ways that men's pathways are not. Furthermore, since the majority of incarcerated women are mothers and reside with their children prior to incarceration (Swavola, Riley, & Subramanian, 2016; Glaze & Maruschak, 2008), the collateral damage caused to society by removing these women from their families and communities is outlined. The practice of separating women who give birth while incarcerated from their newborns is also discussed alongside an evaluation of the current programming within the criminal justice system that some states have implemented to prevent this separation. Finally, research on the experiences of incarcerated women is consolidated with attachment theory to outline necessary clinical components of an alternative to incarceration or preventative program for justice-involved women and their infants utilizing Yale University's Minding the Baby, a highly successful interdisciplinary home visiting program, as a model. An argument is made for the compounding fiscal, societal, and mental health benefits of reforming the current systemic response to postpartum incarcerated women and their infants.

Keywords: incarcerated mothers, attachment theory, reflective functioning, mother-infant psychotherapy

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When thinking about the path I have taken here, I reflect on a time that existed before I could even describe the profession of social work. I was sitting in an undergraduate classroom listening to the first clinical social worker I had ever knowingly met turn many years of dedication to women into the criminal justice system into a profound lecture. Thank you, Ghlee Hanson, for inspiring me to set down this path. You lit a fire within me that I hope will never burn out. I also want to thank Michelle Moran and Kellie Walz for mentoring me as I grappled with the complexities of the criminal justice system and its impact. Deep gratitude and respect goes out to clients who bravely shared their stories with me and allowed me the privilege of witnessing their journey. Finally, I want to thank Jane Hurley-Johncox, Dr. Colin Hollidge, Dr. Lisa Kiesel, and the entire St. Thomas-St. Kate's School of Social Work. I will always be grateful for the profound impact you made on my development as a clinical social worker.

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Secure Attachment Without Bars: Alternatives to Incarceration and Clinical Interventions to Treat the Mother-Infant Relationship

According to The Sentencing Project (2017, 2015), a research and advocacy based non-profit organization, the number of incarcerated women increased by more than 700% between 1980 and 2014 – from a total of 26, 378 to 215, 332 respectively. In prisons, the number of women incarcerated rose at a rate 50% higher than men (The Sentencing Project, 2017, p. 4). It is well documented that the increase of incarcerated women is in part due to the converging of harsher penalties for non-violent and drug-related crimes that were brought about by the War on Drugs in the 1980s and “broken window” policing introduced in the 1990s that focused on low level offenses, such as petty theft, vagrancy, disorderly conduct (e.g. Amnesty International, 2011; Bandele, 2017; The Sentencing Project, 2015; Swavola, Riley, & Subramanian, 2016, p. 23). These shifts in policy along with public and political rhetoric expanded the net of the criminal justice system by producing an

increasingly elastic interpretation of criminal offenses, such as conspiracy – or working together to commit an illegal act – as well as the lowering of thresholds separating minor and serious offenses (for example, by reducing the dollar or drug amount that triggers a felony charge). (Swavola et al., 2016, p. 23)

These changes impacted both men and women, but the most recent data capturing gender shows that they disproportionately impacted women. For example, the arrest rate for drug-related crimes between 1980 and 2009 tripled for women but only doubled for men (Swavola et al., 2016, p. 23). Women involved with complex charges with which their involvement was minimal (e.g. a small-scale seller of drugs in a drug conspiracy case) have much less power in negotiating a beneficial plea deal because they have little relevant information to offer for a lesser sentence (Swavola et al., 2016, p. 23). Moreover, women with very minimal direct involvement (e.g.

taking a phone message or allowing someone to keep items at their home) can be swept up into the criminal justice system through complicity law and are “treated as the principal actor in terms of guilt and punishment” (Swavola et al., 2016, p. 27). In response, an increasing number of jurisdictions are beginning to develop more individualized approaches to prosecution (Swavola et al., 2016, p. 23). These statistics begin to demonstrate that experiences within the criminal justice system differ based on gender.

Between 1986 and 2014, the percentage of women incarcerated in state prisons for a drug offense doubled (The Sentencing Project, 2015, p. 4). Women incarcerated in state prisons are more likely to be incarcerated for a drug or property offense and less likely to be incarcerated for a violent or public order offense than men are (The Sentencing Project, 2015, p. 4). However, since the nation began focusing more policy attention and allocating resources to reducing the prison population in 2008 with *The Second Chance Act*, the women’s prison population has grown outpacing men’s, grown while men’s declined, or declined proportionally less than men’s in seventy-percent of states, according to the Prison Policy Initiative (Sawyer, 2018). In Minnesota, the women’s prison population has continued to outpace the growth of the men’s prison population since 2009 (Sawyer, 2018). A report published by the Prison Policy Initiative notes that it is difficult to determine exactly why women’s rates of incarceration have decreased at a slower rate than men, but they note some hypotheses: women are more likely to receive disciplinary sanctions than men which inhibit the likelihood of earning time off or parole (Houser & Belenko, 2015, as cited in, Sawyer, 2018); women are eligible for fewer diversion programs; and the criminalization of women’s responses to abuse and discrimination – including peripheral involvement in drug arrests and fighting back against domestic violence, adolescent misbehavior, and sex work as a means of supporting oneself (Sawyer, 2018). Since the 1980s,

the number of persons incarcerated has grown exponentially leading to efforts to reform the criminal justice system; however, women have largely been left behind in these efforts, as this paper will attempt to show.

This paper focuses on a specific group within the population of incarcerated women – those who give birth while incarcerated and their newborns – using a theoretically grounded perspective to critically evaluate the various responses to them and propose an alternative to incarceration. Research will be used to outline the pathways women take to the criminal justice system that are different than men's and the communal ramifications of “locking-up” mothers to lay a foundation of understanding of this population within the context of their experiences and multiple systems within the United States. Then, the various responses to experiences of incarcerated pregnant and postpartum mothers and their infants will be highlighted. The author takes an ecological perspective using attachment theory as a clinical lens to build a more robust conceptualization of each party involved – the mother, the infant, and the relationship between them. This information is used to critically review current alternatives to traditional incarceration, prison nurseries and community-based alternatives, that prevent the separation of the mother from the infant due to incarceration. Finally, this knowledge will be consolidated to provide an overview of vital components of a community-based clinical intervention for mother-infant dyads that could be implemented either as a preventative measure to address risk factors that contribute to women's involvement in the criminal justice system or as a comprehensive response to empower them to heal and change the patterns that initially brought them there.

Part I: Understanding Women in the Criminal Justice System

A Gender-Specific Path to Incarceration

Before discussing responses to incarcerated women, it is vitally important to understand

the experience of incarcerated women within the context of their experiences before, during, and after incarceration as well as the pathways that bring them to the criminal justice system. As more data is collected on women involved in the criminal justice system, we are discovering that women enter the criminal justice system in different ways and for different reasons than men do (e.g. Belknap, 2015; Belknap, 2001, as cited in Covington & Bloom, 2006, p. 10). Scholars (e.g. Covington & Bloom, 2008, 2006; Chesney-Lind & Pasko, 2013; Belknap, 2015) oftentimes refer to the explanation of these differences as Pathways Theory. Essentially, the theory holds that the criminal behavior of women is typically a survival response to a history of unmet basic needs or victimization, such as physical or sexual abuse (e.g. Covington & Bloom, 2008; 2006; Richie, 2002, pp. 11-12).

Pathways Theory has been mostly supported by qualitative studies, most notably Daly's analysis of the pre-sentence investigations of men and women entering felony court. Daly (1992) found five unique paths of the women in the study: "harmed and harming" women who were abused as children and acted out, "street" women who ran away from abuse and engaged in petty crimes to survive, oftentimes concurrently with drug use; "battered" women who became involved in the criminal justice system due to being engaged in a relationship with a violent man; "drug-addicted" women who either used or sold drugs within the context of their relationships with significant others or family members; and the "other" women who did not have a history of abuse, mental health problems, or substance abuse (as cited in Gehring, 2016). A more recent study done by Gehring (2016) in 2010 examined Pathways Theory quantitatively (p. 1).

Researchers gathered data from the Inventory of Need Pretrial Screening Tool (ION) administered to 266 pretrial defendants (163 men and 103 women) in Hamilton County, Ohio and analyzed it using path analysis (Gehring, 2016). Results showed a distinct pathway to either

new arrests or a failure to appear for court hearings for women (Gehring, 2016). This pathway consisted of abuse in childhood leading to mental illness, which contributed to substance abuse and later pretrial failure (see Figure 1; Gehring, 2016, p. 128). Conversely, for men, the results showed that childhood abuse, mental illness, and substance abuse were all related, but they did not “work together to influence pretrial failure” (see Figure 2; Gehring, 2016, p. 128).

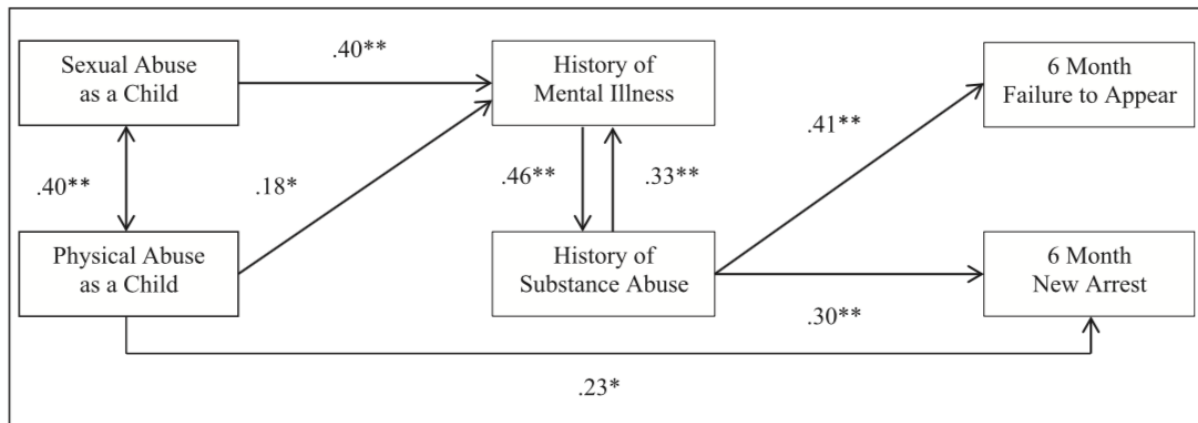


Figure 1. Childhood victimization path model for women. From “A Direct Test of Pathways Theory,” by K. S. Gehring, 2016, *Feminist Criminology*, p. 128. Copyright 2016 by Krista Gehring. Reprinted with permission.

Note. Only paths significant at $p < .05$ are shown.

* $p < .05$ ** $p < .01$.

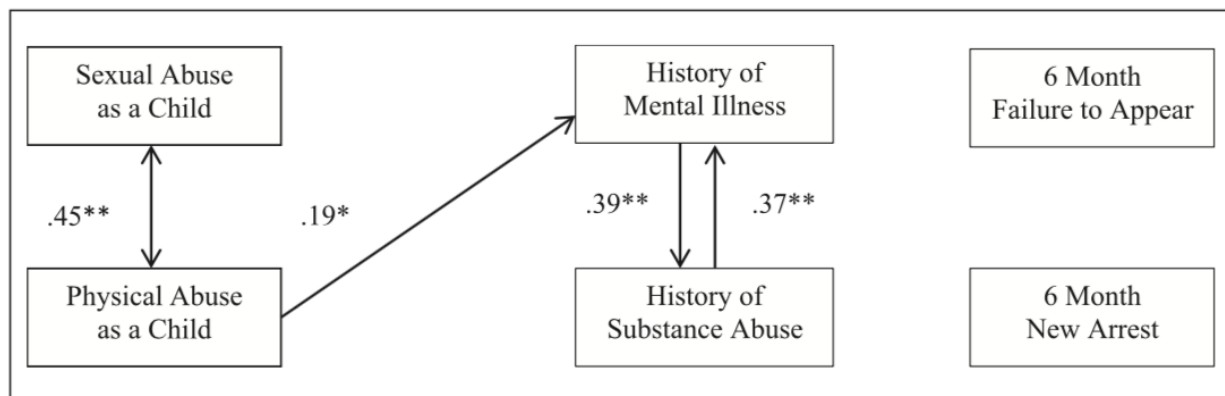


Figure 2. Childhood victimization path model for men. From “A Direct Test of Pathways Theory,” by K. S. Gehring, 2016, *Feminist Criminology*, p. 128. Copyright 2016 by Krista Gehring. Reprinted with permission.

Note. Only paths significant at $p < .05$ are shown.

* $p < .05$ ** $p < .01$.

Thus, Gehring's (2016) work supports Pathway Theory's central claim that women's pathways to the criminal justice system are oftentimes powerfully interwoven with and contingent on contextual and interpersonal factors in ways that men's pathways are not.

While there is not an abundance of quantitative research supporting Pathways Theory, the literature and statistics on incarcerated women in general emphatically support it. Women are more likely than men to begin their prison sentence among the backdrop of a history of abuse, trauma, and mental health concerns (Sawyer, 2018; National Commission on Correctional Health Care (NCCHC), 2014; Messina et al., 2006, as cited in Bloom & Covington, 2008, p. 2; Bloom & Covington, 2006; Covington, 2003). Over 82% of women in prison survived physical or sexual abuse as children, and over 75% of women in prison have experienced severe physical abuse by an intimate partner during adulthood (Correctional Association of New York, n.d., para. 1; Greenfeld & Snell, 1999, p. 1). Since women's experiences of trauma are correlated with mental illness, substance abuse, and repeated involvement in the criminal justice system (Gehring, 2016), it is important to also look at the criminal justice system's effectiveness at alleviating and treating these factors.

The experience of being incarcerated can oftentimes leave women in a more vulnerable, at-risk state than they were prior to entering it. Sexual abuse at the hands of correctional staff, including sexual assault, offensive language, and male staff observing and touching female inmates while naked during searches and supervision is a disturbing reality that many incarcerated women face (Amnesty International, 2011; Buchanan, 2007). The Prison Rape Elimination Act (PREA, Pub. L. No. 108-79) was enacted in 2003 mandating data collection on sexual victimization and mobilizing efforts to eliminate prison rape occurring in every correctional facility in the United States (National PREA Resource Center, n.d.). According to

the U.S. Department of Justice's Bureau of Justice Statistics, allegations of staff sexual misconduct during 2004 (the first year that data collection was mandated by PREA) came from all but one of the state prisons and 41% of local and private prisons and jails it surveyed, 30% of which were substantiated (as cited in Buchanan, 2007; U.S. Department of Justice, 2015).

Women were the victims in more than half of the substantiated cases, an overrepresentation given that the number of men in prisons is far greater (U.S. Department of Justice's Bureau of Justice Statistics, 2005, as cited in, Buchanan, 2007, p. 12). According to the U.S. Department of Justice, data collected between 2009 and 2011 showed that the number of allegations had risen since 2005 – which was consistent with and attributed to the rising prison population – and approximately half (48%) of substantiated incidents involved staff (Beck, Rantala, & Rexroat, 2014). Within this same timeframe, women accounted for 22% of victims of cases in which another inmate was the perpetrator and 33% of cases in which a correctional staff was the perpetrator (Beck et al., 2014). Women only represented about 7% of all prison inmates at this time (Beck et al., 2014). Given that women's pathways to the criminal justice system are fraught with victimization, mental illness, acts of survival, and substance use, the colloquial phrase that the criminal justice system is a "revolving door" is poignant in light of these statistics.

When considering the impact of incarceration as an environment for women, pregnancy and mental health add yet another layer of complexity and vulnerability. In many states, it is still permissible to shackle incarcerated pregnant women before, during, and/or after labor despite the opposition of the practice by various medical associations due to medical risk to the mother and baby (e.g. American Congress of Obstetricians and Gynecologists, 2011; American Civil Liberties Union, 2012; Bandele, 2017). At least half, and perhaps up to 90% of incarcerated women experience clinical levels of depression that can be attributed to current and past life

stressors (Poehlmann, 2005). According to a U.S. Department of Justice Bureau of Justice Statistics report, more incarcerated women met the threshold for severe psychological distress or had been told by a mental health professional that they had a mental health disorder than incarcerated men within the past 30 days, but only just over half (54%) of all individuals who met the threshold for severe psychological distress had received mental health treatment within the facility (Bronson & Berzofsky, 2017, p. 1). The criminal justice system was largely created as a response to men and is ill-equipped to effectively respond to the unique needs of women (Gehring, 2016; Covington & Bloom, 2006; Sawyer, 2018).

The Cost of Mothering from “The Inside”

Not only have women been overlooked in efforts to reduce the number of incarcerated persons in America, failure to focus on preventing the incarceration of women has cost society deeply. The collateral damage that occurs from removing these women from their families and communities is significant. There are over 120,000 incarcerated mothers with children under the age of eighteen (Glaze & Maruschak, 2008). Eighty percent of women in local jails are mothers (Swavola et al., 2016), and over 60% of women in state prisons alone have a child younger than 18 years old (The Sentencing Project, 2015). Maintaining contact with one's children from prison is incredibly difficult since most parents in state and federal prisons (62% and 84% respectively) are incarcerated over 100 miles from their last residence (The Sentencing Project, 2012, p. 2; Walsh, 2016). Additionally, 11% of children with incarcerated mothers experience “at least two changes in caregivers during the period of the mother's incarceration” (Johnson, 1993, as cited in Carlson, 2001, p. 76). Transportation, scheduling, and various other barriers prevent the temporary caregivers from bringing children to see their incarcerated parent (Walsh, 2016; Lapidus, Luthra, Verma, Small, Allard, & Levingston, 2015). In fact, 62% of parents in

state prisons and 84% of parents in federal prisons have not seen their children in-person since beginning their sentence in prison (The Sentencing Project, 2012, p. 2). Sixty-four to eighty-four percent of incarcerated mothers lived with their children prior to being sent to prison; however, while in prison, incarcerated mothers are more likely than incarcerated fathers to have their children living with other relatives or in foster care rather than with the other parent (The Sentencing Project, 2012, p. 2; National Resource Center on Children & Families of the Incarcerated, 2014; Glaze & Maruschak, 2008). An incarcerated mother's efforts to keep her children out of foster care can be financially burdensome since public assistance programs are not designed to support relative caregivers, such as grandparents (Vigne, Davies, & Brazzell, 2008, as cited in, National Resource Center on Children & Families of the Incarcerated, 2014). Eight to ten percent of imprisoned mothers have children in foster care (not including kinship foster care placements; Mumola, 2000). The chances of maintaining custody of one's children while incarcerated is another important aspect to consider.

In 1997, the *Adoption and Safe Families Act* (ASFA) required states to petition to terminate parental rights if a child had been in foster care for 15 of the past 22 months, also known as the "15/22 mandate" (Lapidus et al., 2015, p. 56; Walsh, 2016; Raimon, Lee, & Genty, 2009, p. 123). One in every thirty parents in state prisons has at least one child in foster care (The Sentencing Project, 2012, p. 3). While the length of prison sentences varies greatly depending on the crime and state, according to a report authored by the Bureau of Justice Statistics, women on parole spent an average of 15 to 17 months in prison (Greenfeld & Snell, 1999, p. 11). The aim of AFSA was to reduce the number of children that stayed in foster care indefinitely, but it disproportionately impacted incarcerated parents and their children (Raimon et al., 2009, p. 122). In the five years following the passage of ASFA, proceedings terminating the parental rights of

incarcerated parents more than doubled (Lee, Genty, & Laver, 2005). There are exceptions to the 15/22 mandate that child welfare professionals can use to advocate for preserving parental rights; however, this option is cumbersome and federal audit processes that measure the success of child welfare agencies incentivize termination of parental rights (Raimon et al., 2009, pp. 123-124). Lapidus et al. (2005) draws attention to the “double sentence,” one imposed by the court and one imposed by the child welfare system, that mothers incarcerated for drug offenses serve due to the likely loss of custody of their children (p. 55). The majority of incarcerated women are mothers; removing these mothers from their children and communities has lifelong ramifications for the women, children, and society as a whole that should be considered.

Broadly speaking, children of incarcerated parents have been described by child welfare experts as being one of the most at-risk, yet least-noticed populations (Reed & Reed, 1997; Shlafer, Gerrity, Ruhland, & Wheeler, 2013). Research indicates that the reactions of children to parental incarceration vary among demographic variables (Davies, Brazzell, La Vigne, & Shollenberger, 2008). However, most children with an incarcerated parent face a unique social stigma from peers, experience difficulties forming and maintaining secure attachments, exhibit behavioral problems, require more help in school, and are more likely to abuse drugs or alcohol, among other things (Eddy & Poehlmann, 2010; Bendheim-Thoman Center for Research on Child Wellbeing & Social Indicators Service Center, 2008; Hairston, 2007; Margolies & Kraft-Stolar, 2006). Research has also shown that the loss of a parent to incarceration carries a distinct experience of shame and stigma for children that is unique from other types of parental loss (Davies et al., 2008). Lapidus and colleagues (2015) note that children separated from their mothers due to incarceration often experience grief in a way that parallels the experience of the mother dying (p. 50). Additionally, these children are more likely to have unstable family

relationships and housing situations, which can lead to further displacement or involvement in the foster care system (Bendheim-Thoman Center for Research on Child Wellbeing & Social Indicators Service Center, 2008; National Resource Center on Children & Families of the Incarcerated, 2014). Thus, separating the mother and child can be the start of a cascade of risk factors that may, ultimately, propel the child back into the same criminal justice system that caused the separation in the first place.

It is important to note that it is difficult to accurately analyze the associations specifically between parental incarceration and poor outcomes because both the parent and child may have experienced co-occurring risk factors prior to incarceration of the parent (Shlafer et al., 2013). However, these characteristics of children with incarcerated parents are so pronounced that parental incarceration is recognized as an “adverse childhood experience” (ACE) among professionals due to its distinguishing combination of trauma, shame, and stigma (Hairston, 2007). Despite all these risk factors and hardships, Nickel, Garland, and Kane (2009) contend that a healthy and positive relationship with an incarcerated parent can alleviate some of the aforementioned risk factors and typically leads to benefits such as fewer behavioral issues and less emotional distress.

Part II: Incarcerated Postpartum Mothers and their Infants

Another oftentimes overlooked aspect of women’s involvement in the criminal justice system is the experience of being pregnant while incarcerated. Several sources estimate that approximately six to ten percent of incarcerated women are pregnant (e.g. Sutherland, 2013; Shlafer, Gerrity, & Duwe, 2015; Greenfield & Snell, 1999). When also considering women who have recently delivered a child, this figure jumps to 25% (Morton and Williams, 1998; Willing, 1999, as cited in Carlson, 2000). In a study funded by the U.S. Department of Justice, DeHart

(2004) and her team interviewed 60 women incarcerated at a maximum security correctional facility to examine the experience of victimization's impact on criminal involvement (p. iii). Using a grounded-theory approach to analyze the data, they found that pregnancy and childbirth were identified by many women as "turning points" – "times when life circumstances seemed to be turning around or rapidly changing for better or for worse" – where they would choose to quit or reduce substance use and feel inspired to "clean up" their lives (DeHart, 2004, pp. iii, 46-48). Similarly, Enos (2001) extensively interviewed women incarcerated without their children in Rhode Island and found that the women separated their identity as a mother from their other identities associated with criminal behavior (e.g. addict, prostitute) and highly valued their maternal role (as cited in Byrne, 2010). They saw their children as potential sources of redemption and sometimes engaged in "role reversal in which children were perceived as critical resources and a last hope" (Enos, 2001, as cited in Byrne, 2010, p. 168). Because of the unique physical and psychological experiences during the perinatal period, it is vitally important to consider women who recently gave birth prior to incarceration, are pregnant while incarcerated, or give birth while incarcerated. The remainder of the paper will explore this experience from various angles – laws and policies that drive it, clinical theory that explains the nuances of it, current systemic responses to it, and proposed interventions to capitalize on this unique phase of life.

Incarcerated Pregnant and Postpartum Women in Minnesota

To offer a frame of reference, in the state of Minnesota, 123 women gave birth between 2009 and 2016 while incarcerated at Minnesota Correctional Facility (MCF)-Shakopee (Minnesota Department of Corrections [MN DOC], 2017), Minnesota's only state prison for females. It is important to note that this is one state prison and does not include the federal prison

and county jails in Minnesota that also house female inmates. This author could not find data collected on women housed in federal prisons and county jails in Minnesota specifically. In 2014, the first law (Minnesota State Statutes § 241.87, 241.88, 241.89; SF2423/HF2833) advocating specifically for the needs of incarcerated pregnant and postpartum women was passed and implemented. The law restricts the use of restraints on and creates consistent requirements for health care – pregnancy tests, STI testing, doula services, mental health assessments, and parenting education – for pregnant and postpartum women incarcerated in Minnesota (see Anderson & Benning, 2015 for a summary of the law, supporters, and more information).

Unfortunately, data on women who give birth while incarcerated is scarce. The Minnesota Prison Doula Project (MNPDP), a program at the Center for Urban and Regional Affairs at the University of Minnesota, has made the experiences of and research regarding mothers incarcerated at MCF-Shakopee more accessible. This paper will use their data combined with state statutes to provide the reader with a general overview of the process of giving birth while incarcerated in Minnesota. According to the MNPDP, when a woman goes into labor while incarcerated she is brought to a hospital and typically monitored by corrections staff at all hours of the day (Gerrity, Baker, & Lo, n.d.). Her family and friends are not allowed to be present for the birth; however, she is able to request support from a doula provided by the MNPDP (Gerrity et al., n.d.). Additionally, she is able to remain with her baby in the hospital, as long as the baby's health permits it and there is not a child protective services order prohibiting contact (Gerrity et al., n.d.). On average, women spend approximately 24 to 48 hours with their newborns before returning to the correctional facility; this is consistent with the national average for women who give birth while incarcerated (Byrne & Benning, 2015). Currently, women who give birth while incarcerated at MCF-Shakopee are separated from their newborns when they

leave the hospital to return to the correctional facility (Gerrity et al., n.d.).

The Minnesota Prison Doula Project collected information on the demographics of the mothers involved in their programming (Schillmoeller, Casey, & Schlafer, 2013). They found that “36.2% [of these women] were raised by someone other than a biological parent... 29.8% were in foster care as children... 49% experienced abuse as a child... and 69% experienced domestic violence in adulthood” (Schillmoeller et al., 2013). The trauma of mother-child separation compounds all of these pre-existing risk factors (Lapidus et al., 2005). Gerrity (2013), program director of the Minnesota Prison Doula Project, reports that many of the women they work with at MCF-Shakopee describe symptoms “consistent with post-partum psychosis, including waking up disoriented and searching for their newborn in the night, suicidal ideation, and splits from time and reality” (p. 11). She also reports that mothers commonly do not see their newborns for months after the birth, and some mothers do not see their child until they are released from prison (Gerrity, 2013).

At MCF-Shakopee, Minnesota’s state prison for women, a variety of programming exists to provide support to mothers. For example, there is a separate living unit that houses inmates who are mothers and provides parenting programming (National Institute of Corrections, 2012). Additionally, there are psychoeducational groups, support groups, a parenting coordinator, opportunities for children to visit, and doulas provided by the MNPDP (Minnesota Department of Corrections, 2010; Gerrity et al., n.d.). Although most pregnant and postpartum women are housed in jails or state prisons, such as MCF-Shakopee, the Bureau of Prisons (BOP) offers a community residential program for women housed in federal prisons called Mothers and Infants Nurturing Together (MINT; Federal Bureau of Prisons, n.d.). MINT is available to women housed at the federal prison located in Waseca, MN; however, it has strict eligibility criteria

(Federal Bureau of Prisons, n.d.; Byrne & Benning, 2015). In order to be eligible for the program, time and behavioral factors must be in the mother's favor: women must be considered "low risk," be eligible for furlough, be in their final trimester of pregnancy, and have less than five years left to serve of their sentence (Byrne & Benning, 2015; Federal Bureau of Prisons, n.d.). The purpose of the program is to promote mother-infant bonding, enhance parenting skills, and prepare for re-entry into the community (Federal Bureau of Prisons, n.d.). Most women are permitted to reside with their newborns for three months (although some stay longer), but they must return to the institution after this time period to finish their sentence (Federal Bureau of Prisons, n.d.). Thus, prior to the baby being born, the mother is responsible for finding an appropriate guardian for the child while she serves the remainder of her sentence in custody (Federal Bureau of Prisons, n.d.). Additionally, the mother is financially responsible for the child's medical care costs while participating in the MINT program (Federal Bureau of Prisons, n.d.). It can be assumed that all of this programming benefits incarcerated women in Minnesota who are "mothering from the inside," but none of these programs comprehensively address the factors that initially led to the mother's incarceration or prevent the separation of the mother-infant dyad long-term.

In 2003, the State Advisory Task Force on Female Offenders (now called Advisory Task Force on Justice Involved Women and Girls) began collecting data for a report at the request of the Minnesota Department of Corrections (MN DOC) Commissioner recommending alternatives to incarceration for female offenders at MCF-Shakopee due to the rising prison population and state budget crisis at that time (MN DOC, 2004, p. 3). They went through a nearly year-long process of reviewing prison trends, learning about the profile of female offenders at MCF-Shakopee, analyzing data on prison alternative options, and, ultimately, forming

recommendations (MN DOC, 2004, p. 7). Their recommendations were “formed using the criteria of public safety, program effectiveness, cost efficiencies, and public sensibilities” (MN DOC, 2004, p. 7). One of their five “most promising recommendations” was to implement a “residential program for the pregnant offender” (MN DOC, 2004, p. 15). Moreover, they provided information regarding one such program that was in place for MCF-Shakopee inmates from 1988 to 2001 called Community Alternative for Mothers in Prison (CAMP; MN DOC, 2004, p. 15). This program was designed to break the cycle of intergenerational crime by providing an opportunity for women who give birth while incarcerated to remain with and care for their newborns at a residential facility in the community (MN DOC, 2004, p. 15). The program included educational classes that were provided through a community vendor (MN DOC, 2004, p. 15). This author could not find an explanation for why CAMP ended in 2001 or rationale for why it was not reinstated following the recommendation of this taskforce. Thus, MINT is the only program in place in Minnesota at this time that provides mother-infant pairs with some time to begin forming an attachment relationship; however, even this program requires the separation of the mother and newborn in order for the mother to complete her sentence.

Impact of Separating the Mother and Newborn

Proponents of preserving the mother-infant relationship often draw on anecdotal evidence, attachment theory, and social justice values to support their stance. However, even if this brand of evidence is not compelling, a logical argument can be made for the multifaceted fiscal and societal benefits of keeping the mother and newborn together. Such immediate benefits would include reduced recidivism, re-entry support for inmates released into the community, improved parenting, enhanced child wellbeing, and community involvement, all of which prompt

a cascade of long-term, compounding benefits.

Financial considerations. A survey conducted by the Vera Institute of Justice in 2011 found that the average annual cost of housing a single inmate in a Minnesota prison was \$41, 364 (Henrichson & Delaney, 2012, p. 10). Four years later Mai and Subramanian (2017) also support this figure by noting that the cost of housing an inmate in prison in Minnesota for the year of 2015 was \$41, 366. They go on to explain that the cost of funding Minnesota prisons in 2015 equaled \$74 per *state resident* or \$403, 729, 705 in total (Mai & Subramanian, 2017). By separating an incarcerated mother from her newborn, the additional cost of that child being physically displaced – along with the mental health and behavioral ramifications associated with that separation – will likely fall on society. According to Goshin and Byrne (2009), public funding typically supports children of incarcerated parents. In cases where the child is cared for by a relative, oftentimes stressors, such as the loss of the incarcerated woman's income, emotional impact on the child, and more, overwhelm the family and negatively affect the wellbeing of the child (Lapidus et al., 2005; Hairston, 2007). One can imagine the effect these stressors could have on maintaining strong family bonds, which research has shown to be a significant predictor of successful re-entry into the community after incarceration (San Francisco Children of Incarcerated Parents Partnership, 2005). Additionally, mother-child separation, most specifically the psychological trauma associated with it, has been shown to increase the risk of recidivism (Boudin, 2005; Margolies & Kraft-Stolar, 2006). Incarcerated mothers are not the only ones that suffer when they are separated from their infants; continuing this practice costs society as well.

Psychological considerations. The separation of the mother and child at birth prompts intense and long-lasting impacts to both. Pennix (1999) reported on interviews with 100 women

incarcerated from the 1970s through the 1990s in the federal prison system (as cited in Byrne, 2010). Every mother interviewed shared “the agony of being separated from her children and the resulting emotional turmoil, including shame, depression, anger, sorrow, and rejection, along with an overwhelming fear that children would never understand the separation” (Pennix, 1999, as cited in Byrne, 2010). More specifically, mother-infant separation at birth can lead to lifelong, multifaceted challenges for the child, such as difficulty coping with stressors, verbal or physical aggression, withdrawal, low self-esteem, and difficulty developing and maintaining relationships with others, among other things (e.g. Lapidus et al., 2005; The Rebecca Project for Human Rights & National Women’s Law Center, 2010; Pojman, 2002; Carlson, 2001). A unique aspect of the perinatal period is the potential to facilitate or inhibit the development of a secure attachment template in the mother-infant relationship. This is one of the most emphasized concerns in the literature on mother-infant separation because insecure attachment, specifically a disorganized attachment template, is a major risk factor for psychopathology and developmental impairment (e.g. American Medical Association, 1997; van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999; Deklyen & Greenberg, 2008, as cited in Byrne, Goshin, & Joestl, 2010; Rutter, 1981, as cited in Carlson, 2001, p. 76). Byrne and Benning (2015) summarize the immediate and ongoing ramifications of separating the mother from her newborn by stating, “In addition to the grief experienced after a child is removed, separating the mother and infant can significantly affect child development and the attachment process over time which, if fostered towards security, builds an infant’s strengths and resilience” (p. 17). Continuing the practice of separating children from their incarcerated mothers at birth perpetuates the likelihood of adverse outcomes for society, mothers, and children alike.

Attachment Theory

When considering the psychosocial impacts of the relationship between an incarcerated mother and her newborn child, attachment theory is an incredibly useful tool to gauge the harmfulness of separation and advocate for bi-generational investment in clinical interventions that reduce, if not eliminate, risk factors. At its most basic level, attachment is a bond between a caregiver and child that is manifested in efforts to be physically close and emotionally in touch with the attachment figure, especially in times of distress (Bowlby, 1982). Ideally, this attachment figure creates a consistently responsive relationship for the child to find both physical and emotional safety in (Goldberg, 1991, as cited in Ballen, 2008). These experiences form an attachment system or internal working models of the self (e.g. I am worthy of care and attention) that guide expectations of and patterns in relationships with others (Fraley, Roisman, Booth-LaForce, Owen, & Holland, 2013; Ballen, 2008). Over time, these internal working models manifest as enduring interpersonal tendencies, including affective and cognitive components, that greatly impact one's relationships (Bowlby, 1973, as cited in Ballen, 2008; Main, Kaplan, & Cassidy, 1985). Generally, internal working models of attachment can be divided into two categories: secure and insecure. The "essence" of secure attachment is "the alignment of internal experiences, or states of mind" – which is also known as emotional attunement or mental state resonance – between a child and a caregiver (Siegel, 1999, p. 142; Fraley et al., 2013). In contrast, insecure attachment models arise from patterns of communication that are inconsistent and not contingent on what is occurring between the infant and the caregiver (Siegel, 1999; Fraley et al., 2013). There are various contextual factors, including but not limited to the caregiver's attachment history and bio-psycho-social stressors, that impact the development of attachment relationships.

Research regarding infant development and attachment contends that every child needs at least one consistent and responsive caregiver, especially during infancy and early childhood (e.g. Schore, 2001; Bowlby, 1982; Dawson, Ashman, & Carver, 2000). As Bowlby contended decades ago, infants are driven to attach to their caregivers through a genetically determined motivational system, whether or not those caregivers are responsive to them (Main, Hesse, & Kaplan, 2005; Schore & Schore, 2008). According to the American Medical Association (1997), a child's first year of life and the attachment that forms within the first few months of that year are critical to all aspects of his or her development (as cited in Fearn & Parker, 2004, p. 39). In other words, insecure attachment could be one of the earliest indicators of poor developmental outcomes, which also makes clinical work focusing on the attachment relationship between the infant and their primary caregiver one of the earliest intervention opportunities. Though insecure attachment is not considered psychopathology, it does create a risk of psychopathology, in addition to patterns of psychological and social dysfunction (Siegel, 1999; van IJzendoorn et al., 1999; Deklyen & Greenberg, 2008, as cited in Byrne et al., 2010). There have been consistent findings that although genetic factors may make one vulnerable to psychopathology, environmental factors are highly influential in how the symptoms present themselves (Siegel, 1999). Early attachment relationships are the environment in which "genetically preprogrammed but experience-dependent brain development" unfolds (Siegel, 1999, p. 112). Early interpersonal experiences directly impact how neurons connect with one another (Siegel, 1999). Thus, one's attachment template serves as an organizational component of the mind providing benefits in the case of secure attachment (e.g. flexibility, adaptability) or hindrances in the case of insecure attachment (e.g. uncertainty, rigidity). As Fonagy & Target (1997) note, conduct disorders and borderline personality disorder contain features that are characteristic of self-organization that

develops out of insecure attachment relationships (p. 694). Longitudinal studies show that children who develop healthy attachments to a primary caregiver through consistent contact and nurturing are less likely to experience social and emotional difficulties later in life (Benoit, 2004; Villanueva et al., 2009). Thus, the use of attachment theory to conceptualize both the early experiences of incarcerated mothers and their present-day role as a mother promotes valuable multi-generational treatment intervention options.

Functions of Attachment

Attachment has various functions within the human experience. At its most basic level, attachment motivates an infant to seek closeness with primary caregivers and communicate with them to establish physical safety and survival (Siegel, 1999; Ainsworth, 1989). But, a more complex function of attachment is to utilize a parent's mind to organize the processes of the infant's mind (Siegel, 1999). The caregivers' reaction to the infant provides the infant with an indication of the "meaning of their actions" (Simms/Mann Institute, 2016b). Organizing the infant's brain in this way provides the scaffolding on which the rest of development – including neuronal growth, emotion regulation skills, and the ability to maintain relationships – is built (Siegel, 1999). One example that illustrates organization of an infant's mind is the process by which a caregiver modulates negative emotional states by making uncomfortable emotions more tolerable and understandable while providing a soothing, safe environment for the child (Siegel, 1999). In these experiences, the infant is "feeling felt" by the caregiver who is responsive to signals the infant is sending (Siegel, 1999, p. 176). This process of sending, receiving, and responding to signals is constantly reciprocal, prompting synaptic connections in the infant's brain and laying down both an attachment pattern and a foundation for future development.

Throughout this ongoing conversation, children are discovering themselves within the

eyes of their caregivers (Fonagy, Gergely, Jurist, & Target, 2002). It is important to acknowledge that this presents the caregiver with the tenuous task of “hold[ing], tolerat[ing], and re-present[ing] the range of [the child’s] diverse and contradictory mental states” (Slade, Sadler, Dios-Kenn, Webb, Currier-Ezepchick, & Mayes, 2005). Slade and colleagues (2005) illuminate that this continued process, though incredibly complex and trying, is also regulating for the parent, and parental skillfulness in this area mitigates their own vulnerability to feeling disorganized, dysregulated, and impulsive in relation to their child. All the while a parent’s own attachment history largely influences their expectations, patterns of relating, and attitudes in the present (Ballen, 2008; Main, 1995). Researchers assessing attachment within two New York state prison nursery programs using the Adult Attachment Inventory measure found that 66% of women in their sample ($N = 30$) reported insecure attachment styles (Byrne et al., 2010, p. 390). Although the sample size is small, the findings of this study are consistent with the background provided on the experiences of most incarcerated women earlier in this paper. Trauma can profoundly inhibit a mother’s ability to practice reflective parenting (Fonagy et al., 2002). The child’s needs and fears can be “overwhelming and profoundly evocative,” prompting defensive processes that protected the mother against trauma in the past (Slade et al., 2005, p. 3; Fraiberg, 1980; Lieberman, 1997). If a mother is wrestling with her own trauma and attachment history, there is risk that she will read the child’s cues with “distortion or misattribution” (Lieberman, 1997, as cited in, Slade et al., 2005, p. 3). “Ghosts in the nursery” is a colloquialism oftentimes used in the literature to describe how the attachment history of parents is present within their own parenting (e.g. Fraiberg, Adelson, & Shapiro, 1975). Alicia Lieberman, developer of Child-Parent Psychotherapy and director of the Child Trauma Research Program at San Francisco General Hospital, explains:

The ghosts in the nursery are the suppressed parts of our lives where we felt unresolvable fear and where we could not turn to our parents or other adults to help us with those fears. And so those fears were transformed into self-protective anger because we feel so much stronger when we are angry than when we are afraid. And children who feel helpless need to find someplace in themselves that makes them feel strong when they cannot rely on their parents for assistance. And those patterns of transforming anger as a mechanism to fight fear get re-enacted with the children that they have. So that when a baby cries, the parent says, 'That crying is not important. Shut up.' (Simms/Mann Institute, 2016a)

When this happens, the child may find the mother's responses confusing, thereby inhibiting the development of a coherent sense of self (Crittenden, 1994, p. 89, as cited in Fonagy & Target, 1997, p. 686). Thus, according to the interaction described above, these women are not only struggling themselves with their own past experiences with their caregivers, but they are at risk of continuing the same pattern with their own children.

Herein lies the heart of many interventions that aim to improve infant-parent attachment relationships. As explained previously, the communication between mother and infant during which the mother is sensitive and responsive to the signals the child is sending creates an organized experience for the child in which emotional states are held, regulation is taught, and safety is created (Siegel, 1999). For the purposes of this paper, this artful communication between caregiver and infant will be referred to as reflective functioning or mentalizing. The interpersonal and intrapersonal construct of reflective functioning was introduced by Fonagy and his colleagues just over 20 years ago and is essential to develop and maintain relationships as well as emotion regulation skills (Slade et al., 2005; Slade, 2006). Reflective functioning is defined as a continuum of one's capacity to mentalize, that is to imagine one's own mental state

or another's (Fonagy et al., 1995, as cited in Slade, 2006, p. 641). As Slade and colleagues (2005) note, the ability to "understand the mind of the other, to make meaning of behavior – one's own and others – in light of underlying mental states and intentions" is a "crucial human capacity" (p. 2; Slade, 2006; Siegel, 1999). Fonagy & Target (1997) suggest that the ability to mentalize is incredibly influential in self-organization and identity (p. 679). After all, the degree to which one can effectively "integrate and contain" various life experiences is contingent upon their ability to think of, know, and understand those experiences as they are, with as little distortion as possible (Slade, 2005; Fonagy et al., 2002). The ability to mentalize grows out of one's own interpersonal experiences, especially at a young age, of being known and understood by caregivers (Slade, 2005). When the mental health and attachment history of the mother are treated with special consideration for the relationship between her and the infant, the wellbeing of both is enhanced.

Internal Working Model of Attachment

These moment-by-moment interactions during which the infant sends signals to the caregiver and the caregiver responds become "encoded in implicit memory as expectations and then as mental models or schemata of attachment, which serve to help the child feel an internal sense of what John Bowlby called a 'secure base' in the world" (Siegel, 1999, p. 91). This mental model will be referred to as the internal working model, a term coined by John Bowlby (Siegel, 1999; Pearlman & Courtois, 2005, p. 451). This model is used to "bias present cognition for a more rapid analysis of an ongoing perception" and to assist the mind in anticipating what is likely to come next (Siegel, 1999, p. 96). In this way the brain impacts decisions made in the present by incorporating what it has learned from the past (Siegel, 1999). Siegel (1999) summarizes how attachment interactions with parents build one's internal working model, which

subsequently impacts interpersonal experiences as adults:

Beyond the first half year of life, we each have a set of ‘virtual others,’ which are continually evoked during interactions with other people. If past attachments have been filled with uncertainty and intrusion, then the virtual other – the internal representation of the attachment figure – may interfere with the ability to clearly perceive others’ bids for connection. The individual may (mis)perceive others’ behaviors in light of a virtual other that creates caution and uncertainty. . . . The virtual other can be so dominant in an individual’s mind that the actual other has little chance of being directly and accurately perceived during a current experience. (Siegel, 1999, p. 129)

He goes on to explain that being the child of such a person creates the sense of being “unseen” and can lead to a sense of a “false self” (p. 129). In other words, if an adult does not have their own secure attachment figures to draw on while parenting, they are at risk of misinterpreting their child’s behavior and causing the child to feel confused, unsafe, misunderstood, and other things that could have a detrimental impact on their development and quality of life as adults.

Strange Situation Procedure. The origins of attachment classifications go back to Mary Ainsworth’s groundbreaking Strange Situation study in the 1950s, which contributed to the development of attachment theory. In addition to the secure and insecure classifications, there are three sub-classifications of insecure attachment that have been identified. In the Strange Situation study, an infant was either alone with its mother, with the mother and a stranger, alone with the stranger, or simply alone in a series of interactions designed to create an increasing need for the child to seek support and physical closeness to their attachment figure (Ballen, 2008; Siegel, 1999). Ainsworth’s observations of how the child coped with these heightened needs and the strategies they turned to were considered to be indicative of the attachment relationship

(Goldberg, 1991, as cited in Ballen, 2008). Ainsworth found that, in general, three distinct patterns of actions played out when the infant was reunited with the mother; she classified these attachment responses as secure, avoidant, and ambivalent (Siegel, 1999). While secure attachment is ideal, all of these attachment classifications are considered “organized” because they all prompt the infant to adapt to their environment in order to increase the likelihood of safety (Main, 1900, as cited in van IJzendoorn et al., 1999). Later, a fourth attachment classification emerged from a study conducted by Main and Solomon (1986) that discovered that Ainsworth’s initial three categories did not fully capture the behaviors commonly presented by children with backgrounds of abuse or neglect during the Strange Situation Procedure (van IJzendoorn et al., 1999; Siegel, 1999, p. 73; Duschinsky, 2015; Ballen, 2008). Main and Solomon (1986) found that these children did not display a consistent way of responding to the distress created in the Strange Situation Procedure but rather displayed behaviors that indicated confusion and tension (e.g. distress upon parent leaving and indifference upon their return, infant seeking comfort from the stranger when the parent is available; Main & Solomon, 1990). Thus, this classification was named disorganized. Therefore, the four classifications of attachment commonly referred to today are secure, avoidant, ambivalent, and disorganized.

Secure. Children who develop secure attachments with their caregivers are able to explore the world and develop relationships with others all the while knowing that they can return to their caregiver as a safe haven if things go awry (Siegel, 1999). In general, the parent is attuned to the signals the child is sending and responding in ways that are helpful for the child to make meaning out of experiences while also organizing and containing distress. The parent is easily accessible to the infant when they seek physical or emotional proximity (Main et al., 1985). Additionally, the child feels comfortable expressing their distress to the parent and is

confident that the parent will consistently provide support (Ainsworth, Blehar, Waters, & Wall, 1978). Because of all the aforementioned benefits of a secure attachment, this is considered to be the ideal attachment working model. It is important to note that there are always times of disconnection within a parent-child dyad; however, it is vital to the child's development that consistent, predictable patterns of communication are the norm (Siegel, 1999). In each model of insecure attachment, there is a problem with the process of repairing the relationship after a rupture has occurred to promote necessary connection (Siegel, 1999). Thus, parents oftentimes can benefit from support in how to manage the effects of their own implicit and explicit memory recall, so that they are able to engage in an attuned repair process with their child when ruptures occur (Siegel, 1999).

Avoidant. An avoidant attachment working model has been found to form when caregivers are emotionally unavailable, unresponsive to their children's signals, and unable to meet their children's needs once they have been made known (Main et al., 1985; Siegel, 1999). As a result, the child learns that frustration can be reduced by avoiding proximity to others and reducing expectations (Siegel, 1999). It is important to note that avoidantly attached children showed marked physiological responses to the coming and going of their caregiver in the Strange Situation study despite outwardly appearing to be ambivalent (Fox & Hane, 2008, as cited in, Siegel, 1999). Furthermore, studies have shown that affect attunement is not predominant in the relationship between the infant and caregiver (e.g. Main et al., 2005). Thus, the child's "internal working model of attachment is that the parent has never been useful at meeting his emotional needs and is not attuned to his state of mind" (Siegel, 1999, p. 120; van IJzendoorn et al., 1999). Because the caregiver is not able to hold the child in mind, the child is at risk of not developing the ability to practice reflective functioning with themselves or others (Siegel, 1999). Siegel

(1999) contends that “this pattern of attachment organizes the mind to reduce access to emotional experience and information in memory;” thus, the mind is impaired as it strives to “develop an integrated sense of self across time in relationship to others” (p. 127). Naturally, these children may grow up to feel disconnected on a conscious or subconscious level and show a tendency of disavowing the importance of relationships (Siegel, 1999).

Ambivalent. An ambivalent attachment relationship typically forms when caregiver responses to the infant are inconsistent (Ainsworth et al., 1978; Main et al., 1985). The child experiences uncertainty regarding whether or not their own needs and emotional states will be attuned to because experience has taught them that the caregiver is only intermittently available (Siegel, 1999). Another characteristic of this classification is that the caregiver is unable to discern, or sometimes respect, when to move towards the child and when to create space; thus, there are moments of intrusiveness in the relationship that appear “to be emotional invasions into the infant’s state of mind” (Siegel, 1999, p. 127). The parent is not ill-willed in pursuing the child, but rather is attempting to connect in a way that is not in alignment with the child’s communication (Siegel, 1999). Siegel (1999) provides the example of a parent suddenly grabbing a child and showering her with kisses, which, albeit an effort to connect, disrupts what the child was focused on doing. This experience communicates to the child that their own mental state may be interrupted by the caregiver in unpredictable ways as opposed to “predictably enhanced” as is the case when the caregiver is mentalizing the child (Siegel, 1999, p. 129). Related to mentalizing, the caregiver is inconsistently able to accurately read the infant’s signals and respond with direction on “how to feel,” which leaves the child without a consistent method of regulating their own internal states (Siegel, 1999, p. 133; Schore, 2001; Coan, 2008, as cited in, Siegel, 1999, p. 133). The child is left with “an internal sense of uncertainty,” a pressing need

for continuing comfort, and ambivalence toward self-regulating (Siegel, 1999, p. 129). Children who develop an ambivalent internal working model typically experience “anxiety, uncertainty, and ambivalence” in attachment relationships as adults (Siegel, 1999, p. 143). They commonly possess an attitude of caution in relationships and expect intrusion or loss from others (Siegel, 1999). These children may grow up to live out a self-fulfilling prophecy in which all new relationships are viewed through the filter of their attachment history leading them to conclude that all relationships are “inconsistent and unreliable” (Siegel, 1999, p. 131).

Disorganized. Finally, disorganized attachment is the fourth attachment classification that was added by Main and Solomon (1986) to describe common reactions of children within the Strange Situation Procedure who had experienced abuse or neglect. Drawing on what is known about the prevalence of adverse experiences (e.g. poverty, abuse, trauma) in the lives of incarcerated women as discussed previously, they are more likely to have experienced a disorganized attachment relationship with their caregiver and are at risk of re-creating this same relationship with their own children (Ballen, 2008). In a meta-analysis of 80 studies, van IJzendoorn and colleagues (1999) found that “in groups of mothers with alcohol or drug abuse ($n = 144$), the percentage of disorganized infants was 43%” (p. 233). They also found that nearly half of the children (48%) in “groups of maltreating parents ($n = 165$)” exhibited disorganized attachment templates (van IJzendoorn et al., 1999). As discussed previously, over 82% of women in prison survived physical or sexual abuse as children (Correctional Association of New York, n.d., para. 1; Greenfeld & Snell, 1999, p. 1). Because this classification so closely reflects the documented experiences of incarcerated women and what can be predicted about their possible challenges as mothers, this classification will be discussed more thoroughly than the others to illustrate the complex multi-generational impact of attachment in this population.

The hallmark feature of disorganized attachment is the infant's paradoxical situation of having a parent that is both the source of fear *and* the only option as a potential haven of safety (van IJzendoorn et al., 1999). Because the caregiver is the source of fear and distress, the child is unable to use the caregiver to organize their experience or regulate their emotions (Siegel, 1999; IJzendoorn et al., 1999). Moreover, without the option to fight or flee due to the nature of the relationship, the infant can only freeze, which raises concern about the child engaging in dissociation later in life (Carlson, 1998, as cited in Ballen, 2008). Carlson (1998) found a "strong association of $r = .36$ between dissociation and disorganization" in a sample of 128, low socioeconomic status, 17-year-old participants that were classified as disorganized when they participated in the Strange Situation Procedure at two years of age (as cited in van IJzendoorn et al., 1999). Disorganized attachment often occurs in parent-child relationships when abuse or neglect are part of the relationship, but it can also develop when the parent is struggling themselves with unresolved loss or another traumatic experience (van IJzendoorn, 1995; van IJzendoorn et al., 1999). Additionally, marital discord and parental depression can lay the foundation for disorganization because these contextual factors increase the likelihood of unpredictable parental responses to the child (see van IJzendoorn et al. for a meta-analysis, 1999; Siegel, 1999).

It has been proposed that *unresolved* loss, not loss itself, is an important feature in the development of disorganized attachment templates (Siegel, 1999; van IJzendoorn, 1995; van IJzendoorn et al., 1999); however, additional research is needed to explain the exact impact of loss or trauma in the parent's life on the attachment relationship. It has been hypothesized that intrusions of traumatic memories occur during interactions with the infant, which prompt the parent to behave in ways that are frightening to the child (Main & Hesse, 1990). However, a

meta-analysis of 80 studies done by van IJzendoorn and colleagues (1999) found that this only occurred with mothers with an insecure attachment classification; mothers with unresolved loss that endorsed secure attachment representations displayed behavior that was much less frightening (Schuengel et al., 1999, as cited in van IJzendoorn et al., 1999). Another hypothesis is that the infant's expressions of pain or fear can evoke the mother's own experiences of lacking comfort during loss and trauma, which leads her to feel helpless in knowing how to comfort her child (Lyons-Ruth & Jacobvitz, 1999, as cited in Ballen, 2008). Again, she may display frightening affect or behaviors associated with the earlier trauma that do not create a relational interaction in which the infant feels the mother is safe (Lyons-Ruth & Jacobvitz, 1999, as cited in Ballen, 2008). These bi-generational and contextual factors are important pieces of conceptualizing presenting struggles of both a parent and a child. Disorganized attachment is widely considered to be detrimental to child development and a major risk factor in the development of psychopathology (e.g. Lyons-Ruth, 1996, as cited in van IJzendoorn et al., 1999; Slade, 2006; Siegel, 1999). Disorganized attachment has been associated with a variety of complications in adolescence and adulthood that closely resemble its own characteristics. These challenges include, but are not limited to, using hostile behavior as a way of relating to peers (Lyons-Ruth, Alpern, & Repacholi, 1993, p. 572; Siegel, 1999), trouble modulating energy associated with different emotional states, difficulty sustaining attention, and rarely experiencing positive social interactions (Sroufe, Egeland, Carlson, & Collins, 2005; Atkinson & Goldberg, 2004, as cited in, Siegel, 1999, p. 109; Siegel, 1999), all of which greatly reduce their quality of life and chances of developing a social support system.

It is important to note that using secure, avoidant, ambivalent, and disorganized categorizations of attachment is just one conceptualization (see Teyber & McClure, 2011 for

another) of the various ways we adapt to our relationships as both children and adults. While these classifications can be helpful when conducting research and describing attachment in academic or clinical settings, it is not unlikely for an individual to present with aspects of various classifications based on the entirety of their attachment history and experiences (Siegel, 1999). For the purposes of this paper, understanding the general classifications of secure and insecure attachment and the ramifications of them, which remain consistent within the various forms of conceptualizing attachment, is key. Much of attachment research has demonstrated that one's self-reported attachment template (i.e. thoughts, feelings, and behaviors in close relationships), greatly impacts one's ability to emotionally regulate, general wellbeing, and the quality of interpersonal relationships (Fraley et al., 2013). When considering how early attachment experiences influence adults, the Adult Attachment Inventory (AAI) is a useful clinical tool.

Adult Attachment Inventory. The AAI measures an adult's "state of mind" (i.e. mental representations) with regard to attachment (van IJzendoorn, 1995, p. 387) by prompting them to recall their own relationships with parental figures (Byrne et al., 2010, pp. 30-381). An adult's state of mind with regard to attachment is predictive of parental responsiveness (van IJzendoorn, 1995; Ballen, 2008). The idea is that the internal working model of attachment can be triggered during the act of parenting, and, if it is insecure, it could overwhelm and restrict the parent's ability to interpret and respond to their child's signals (Ballen, 2008). In fact, it has been demonstrated that a parent's Adult Attachment Inventory classification can predict which Infant Strange Situation classification their child's attachment behavior will correspond with (e.g. Main et al., 1985). Much like the Strange Situation Procedure, the AAI distributes responses into four categories: secure/autonomous, dismissing, preoccupied, and unresolved/disorganized (see Table 1). The unresolved/disorganized classification implies that there was some sort of trauma (e.g.

loss, physical or sexual abuse) that was left unresolved (Ballen, 2008), which is consistent with the previously discussed hypothesis that unresolved loss may contribute to disorganized attachment (Siegel, 1999; van IJzendoorn, 1995; van IJzendoorn et al., 1999).

Table 1
Comparison of Adult Attachment Inventory and Infant Strange Situation Procedure Classifications

AAI Classification	Infant SSP Classification
Secure/autonomous	Secure
Dismissing	Avoidant
Preoccupied	Ambivalent
Unresolved/disorganized	Disorganized

Meta-analytic data collected by van IJzendoorn & Bakermans-Kranenburg (1996) indicate that approximately 28% to 40% of mothers in high-risk populations are classified as unresolved when the AAI is administered (as cited in Ballen, 2008).

Malleability. It is important to note that the internal working model of attachment can be changed even into adulthood (Siegel, 1999; Bowlby, 1988, as cited in van IJzendoorn, 1995). While experiences early on in life are very impactful and, as described previously, develop the foundation for the development of the brain, the attachment template in adults is continually influenced by experience (Siegel, 1999). Exactly to what extent the brain can be influenced by experiences later in life is a question that is still being explored (Siegel, 1999). Some contend that adverse early attachment experiences, such as severe neglect or abuse, may impact the structure of the brain in irreparable ways (e.g. Schore 2002; MacDonald et al., 2008, as cited in Siegel, 1999). Thus, it is important to continue focusing time and resources on enhancing parent-child relationships from a preventative standpoint and not lose sight of how environmental

factors, such as poverty, incarceration, and violence, can limit parental capabilities. This knowledge of attachment theory and the impacts of attachment relationships throughout the entire lifespan serve as a tool for both understanding incarcerated women and planning interventions that enhance their wellbeing, especially when considering women who become mothers while incarcerated.

Prison Nurseries and Community-Based Alternatives to Incarceration

Since 1858 some states have prevented the separation of mother and child during incarceration by implementing prison nursery programming or community-based alternatives (Poehlmann, 2005; Villanueva, From, & Lerner, 2009) that allow the mother and child to remain together. Each of these options have unique benefits and risks. Research on the existing programming provides a valuable guide for the development of creative responses to mothers who give birth while incarcerated.

Prison nursery programs allow the mother and infant to remain together within a designated unit of the prison until the infant reaches a certain age. Typically, only women with nonviolent histories are eligible to participate, and programming varies greatly depending on the facility (Villanueva et al., 2009). There are approximately 12 prison nursery programs nationwide (Washington State Department of Corrections [DOC], 2017; Fritz & Whiteacre, 2016). In 2015, Byrne and Benning (2015) estimated that prison nursery programs in the U.S. provided “approximately 110 infants with access to their mothers on any single day” (p. 17). Washington’s Residential Parenting Program (RPP) is considered to be the most comprehensive and progressive in the nation (Jbara, 2012, p. 1834). Even the state laws regarding the program emphasize the importance of the parent-infant relationship (see WA Rev Code § 72.09.495). RPP has been running since 1999 (Washington State DOC, 2017, p. 1). This program provides doulas

to women during pregnancy, allows children to reside with their mothers for up to three years, and incorporates an Early Head Start program, among other things (Villanueva et al., 2009). Other states have opted to respond to mothers who give birth while incarcerated through community-based alternative programs that allow mothers and infants to reside together in a designated facility in the community (Villanueva et al., 2009). Children in these programs can typically reside with their mothers until they are at least school age (Villanueva et al., 2009). Community-based alternatives are commonly made possible through partnerships between non-profit organizations in the community and state corrections departments (Villanueva et al., 2009). Both prison nurseries and community-based alternatives typically offer parenting programming, education, chemical health treatment, and re-entry support (Jbara, 2012; Villanueva et al., 2009). In a report developed by the Women's Prison Association compiling information on prison nurseries and community-based alternatives in the United States, community-based alternatives were advocated for as the best use of state resources because they cost much less than prison nurseries and better prepare women to successfully parent and thrive in the community (Villanueva et al., 2009).

Benefits. In 2000, researchers began to study outcomes for both mothers and infants residing in some of the oldest prison nurseries in the nation (Byrne & Benning, 2015; Byrne, Goshin, & Joestl, 2010). In a five-year-long study, Byrne and colleagues (2010) assessed the intervention outcomes of two prison nurseries within the New York State Department of Correctional Services prison system. Within the context of this larger study, their team conducted a smaller study assessing the attachment outcomes of 30 mother-infant pairs who started participating in prison nursery programming immediately after discharge from the hospital following birth (Byrne et al., 2010). Approximately half (14) of the mother-infant dyads

were released to the community within a year due to their sentence term ending, which provided the opportunity to compare attachment outcomes for dyads residing in the prison nursery for different lengths of time (Byrne et al., 2010). Their measures included the Strange Situation procedure (SSP; Ainsworth et al., 1978) and the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996, as cited in Byrne et al., 2010). They found that the AAI distribution of their sample contained a “significantly elevated rate of insecure attachment” (Byrne et al., 2010, p. 390). After a “brief but individualized and repeated intervention,” the SSP revealed that the percentage of infants falling under the disorganized category of attachment was significantly less than expected based on the proportion of mothers with an unresolved attachment status, according to the AAI (see Table 3; Byrne et al., 2010, p. 390). In fact, the group that resided with their infants for at least one year in the prison nursery “had a significantly greater proportion of secure infants than meta-analyzed community samples of mothers with low income, depression, or drug/alcohol abuse” (Byrne et al., 2010, 375). Thus, they concluded that even if a mother’s own attachment organization is considered insecure, she can raise an infant within the prison nursery setting with a secure attachment template at rates comparable to infants in low-risk settings in the community (Byrne et al., 2010, p. 386). They also found that secure attachment was more likely in the group that resided together in the prison nursery for at least one year than in dyads that were released into the community sooner (see Table 2; Byrne et al., 2010).

Table 2

Concordance of Secure/Insecure Maternal AAI and Infant SSP Classifications

		Maternal attachment representation (AAI)		
	Infant–mother attachment (SSP)	Insecure <i>n</i> (%)	Secure <i>n</i> (%)	Total <i>n</i> (%)
Total sample (<i>N</i> = 30)	Insecure	8 (27%)	4 (13%)	12 (40%)
	Secure	12 (40%)	6 (20%)	18 (60%)
	Total	20 (67%)	10 (33%)	30 (100%)
Year co-residence (Group 1, <i>n</i> = 16)	Insecure	3 (19%)	1 (6%)	4 (25%)
	Secure	9* (56%)	3 (19%)	12 (75%)
	Subtotal	12 (75%)	4 (25%)	16 (100%)
Brief co-residence (Group 2, <i>n</i> = 14)	Insecure	5 (36%)	3 (21%)	8 (57%)
	Secure	3 (21%)	3 (21%)	6 (42%)
	Subtotal	8 (57%)	6 (42%)	14 (99%) ¹

Note. ¹Total is less than 100% because of rounding. *There was significantly more insecure mother to secure infant discordance in Group 1 than anticipated by the AAI ($X^2 [1, N = 16] = 14.3, p < .001$). From “Intergenerational Transmission of Attachment for Infants Raised in a Prison Nursery,” by M. W. Byrne, L. S. Goshin, and S. S. Joestl, 2010, *Attachment & Human Development*, 12(4), p. 385. Copyright 2010 by Taylor & Francis. Reprinted with permission.

It was suspected that overwhelming environmental factors (e.g. lack of steady income, difficulty finding childcare, re-engaging in social relationships) experienced by women who left the prison nursery earlier than a year may have contributed to the differences in secure attachment outcomes between the groups (Byrne et al., 2010). They also drew attention to the importance of considering the “longevity of the attachment process” when developing programming for this population given that their findings indicated a longer stay was protective of attachment (Byrne et al., 2010).

This formed mother-child relationship makes any future separation from the child uniquely painful, thus acting as an incentive for the mother to not re-engage with the criminal justice system (Goshin, Byrne, & Henninger, 2013, as cited in, NCCHC, 2014). Marshall (2011) prepared a report analyzing benefits of various prison nursery programs throughout the country.

To capture recidivism rates, he surveyed prison administrators of seven prison nursery programs around the country (see Table 3; Marshall, 2011).

Table 3

Recidivism Rates for Prison Nursery Programs as Compared to the General Prison Population

	State						
	*IL	IN	OH	NE	NY	WA	WV
General Population	51%	34%	30%	21%	26%	40%	24%
Nursery Program	0%	11%	17%	10%	13%	11%	0%
Time-Frame in Years	4	3	10	17	3	12	2

Note. *IL data retrieved from state webpage. Adapted from “Analysis of Prison Nursery Benefits and Program Strategies: Alaska Department of Corrections Opportunity for Reduction in Recidivism and Improved Bonding Between Incarcerated Mothers and their Infants” by L. D. Marshall, 2011. No copyright.

According to Marshall’s (2011) findings, participants of the prison nursery programs had significantly lower recidivism rates, ranging from 43.33% to 100% lower, when compared to the general prison population.

Some researchers have sought to report on prison nurseries from the viewpoints of mothers involved with them. Gabel and Girard (1995) documented perspectives of a convenience sample of 26 incarcerated mothers involved with New York State prison nurseries (as cited in Byrne, 2010). The women reported that the opportunity to co-reside with their babies provided them with “a sense of bonding, improved parenting skills, and self-respect” (Gabel and Girard, 1995, as cited in Byrne, 2010, p. 168). Similarly, Schehr (2004) spent several months with 23 women involved in a prison nursery and conducted extensive interviews reflecting on the impact of the prison nursery program with three of them eight years later (as cited in Byrne, 2010). Qualitative analyses revealed themes of “safety, affiliation, change, and resilience” and a deep longing to reconnect with past participants and staff of the prison nursery amidst the backdrop of

adversity associated with re-entering the community (Schehr, 2004, as cited in Byrne, 2010, p. 169). These studies, though few, shed light on the potential immediate and longitudinal impact of this kind of programming.

Moreover, the data on the cost of running a prison nursery program shows that this approach is more cost-effective than incarcerating the mother and supporting the child in the community as both are typically paid for with public funds (e.g. foster care, public assistance; Goshin & Byrne, 2009, p. 7). Prison nursery programs in New York and Ohio each spent approximately \$90,000 in 2002 to run programs caring for approximately 20 infants and their mothers (Idaho Office of Performance Evaluations, 2003, as cited in, Goshin & Byrne, 2009, p. 6). An Ohio newspaper noted that each child in their prison nursery program costs the state only \$4.65 per day (Zachariah, 2006, as cited in Goshin & Byrne, 2009, p. 6). Washington State has funded its comprehensive prison nursery program as detailed earlier entirely through grants, partnerships with community organizations (e.g. an early head start program, a hospital, a pediatric clinic, child protective services, WIC), and social service funding allocated to the children (Goshin & Byrne, 2009, p. 6). The savings multiply when considering the bi-generational and preventative benefits of this approach.

Criticisms. Despite the success of prison nurseries, they have not gone without criticism. Some advocates of prison nurseries contend that there have not been any findings that the prison nursery environment is detrimental to infants (e.g. Elmalak, 2015), but the research on this varies somewhat primarily in the realm of meeting developmental milestones (e.g. American Medical Association, 1997; Johnston, 2003, as cited in, Goshin & Byrne, 2009, p. 6; Byrne, Goshin, & Josetl, 2010). Some researchers have argued that any developmental lag observed should be attributed to the lack of educational stimulation available in the prison nursery environment

(Goshin & Byrne, 2009, p. 5). Prison nurseries are designed to balance the needs of security in the facility and the requirement of a nurturing environment for the child (Villanueva et al., 2009). An effective argument can be made that, even when the prison environment is taken into consideration, the infants participating in the prison nursery program are experiencing more benefits than they would in typical alternative environments that children of incarcerated parents reside in (Jbara, 2012). Additionally, Kim (2001) raises the concern that the mother is limited in her opportunities to develop and engage with a social support network that she will depend on upon release from prison (as cited in Jbara, 2012). Another concern regarding the mother is that the prison nursery does not provide a real-world environment within which mothers may develop parenting skills (Villanueva et al., 2009). The limited research we have on prison nurseries outlined previously shows that this intervention benefits the attachment relationship, but, as noted in Byrne's (2010) study, environmental factors that women were faced with upon release from prison were suspected to interfere with this benefit. Longitudinal studies (e.g. Carlson, 2001; State of New York Department of Correctional Services, 2002) have estimated that approximately 57% to 62% of women who participate in prison nursery programming maintain custody of their children three to 10 years after release (as cited in Byrne, 2010). These outcomes indicate that more research and innovation is required to further understand incarcerated mothers and develop programming that improves outcomes for both them and their children.

This is a brief overview of prison nursery and community-based alternatives that allow the mother-infant dyad to reside together after birth (for more information see Villanueva et al., 2009; Elmalak, 2015; Byrne, 2010). Both of these options have demonstrated unique benefits and complications from which insights can be drawn. Given that criticisms of prison nurseries are centered on the impact of the environment for both the mother and the infant rather than the

benefits of the intervention, some have recommended that the intervention be taken outside the prison in the form of a community-based alternative (e.g. Krisberg & Temin, 2001; Chesney-Lind & Immariageon, 1995, as cited in Fearn & Parker, 2004; Pojman, 2002). Pojman (2002) contends that community-based residential programming gives mothers a unique opportunity to both develop as mothers and address the issues that contributed to their criminal justice involvement in a supportive environment. Given what is known about the necessity of programming established with inter-disciplinary partners to effectively address the complex needs of incarcerated mothers and the importance of programming lasting a sufficient length of time to allow for meaningful change to be established (Villanueva et al., 2009), it stands to reason that community-based alternatives could potentially offer even more comprehensive and long-lasting benefits than prison nurseries.

Part III: An Intervention Model

Guiding Considerations

There are many important factors to consider when developing this type of intervention: evolving criminal justice reform efforts, clinical theory, potential for interdisciplinary collaboration, and funding resources, among other things. Covington and Bloom (2006), directors of the Center for Gender and Justice and long-term researchers and developers of gender-responsive interventions for justice-involved women, provide an overarching framework to utilize in the development of interventions and services that account for the complexities of this population. They outline six “guiding principle[s]” of developing gender-responsive programming (Covington & Bloom, 2006). The first principle – “acknowledge that gender makes a difference” – involves rejecting the long-held “rule of parity” and responding to the data showing that male and female offenders respond differently to every aspect of the criminal

justice system from their pathways into it, to community supervision, to their habits upon release (p. 13). The second principle – “create an environment based on safety, respect, and dignity” – encapsulates data from a variety of disciplines showing that the environment is an imperative component of improved behavioral outcomes (p. 13). Covington and Bloom (2006) argue that, “a safe, consistent, and supportive environment is the cornerstone of a corrective process. Because of their lower levels of violent crime and their low risk to public safety, women offenders should, whenever possible, be supervised and provided services with the minimal restrictions required to meet public safety interests” (p. 13). The third principle – “develop policies, practices, and programs that are relational and promote healthy connections to children, family, significant others, and the community” – draws the critical and unique connection between women’s actions and their relationships, for better or for worse (pp. 13-14). Covington and Bloom (2006) emphasize that if this one principle is “incorporated into policies, practices, and programs, the effectiveness of the system or agency is enhanced” (p. 13). The fourth principle – “address substance abuse, trauma, and mental health issues through comprehensive, integrated, and culturally relevant services and appropriate supervision” – notes that these issues are therapeutically connected (even though they are traditionally treated separately) and treatment as such is vital to successful re-entry into the community (p. 14). The fifth principle – “provide women with opportunities to improve their socioeconomic conditions” – addresses the reality of the minimal amount of social and fiscal capital women bring with them to the criminal justice system and how quickly these resources can be lost with trauma and substance abuse (p. 14). The sixth principle – “establish a system of community supervision and reentry with comprehensive, collaborative services” – recognizes the compounding weight of burdens (e.g. offender stigma, decreased economic potential, fragmented social services) women oftentimes leave the criminal

justice system with (p. 14). These principles combined with the documented experiences of incarcerated women, attachment theory, and research on currently existing programming provide a framework for clinical intervention that is grounded in theory with consideration for ecological context on micro, mezzo, and macro levels.

While myriad social and systemic challenges typically faced by incarcerated persons prior to incarceration were previously discussed, it is equally important to consider what opportunities exist for creating a sustainable life upon release back into the community for formerly incarcerated women as this phase could be detrimental to progress gained during programming while incarcerated (Byrne, 2010). Previously incarcerated individuals oftentimes have to repair components of their life, including social support, familial bonds, and mental health, that incarceration only made worse (Sawyer, 2018). While bearing the label of “criminal” and wading through the social stigma associated with that – not to mention coping with potentially traumatizing experience of incarceration – these individuals face the daunting task of piecing together the necessary components of a safe, sustainable life, including finding adequate housing, financial resources, and social support, among other things. The *Housing Opportunity Program Extension Act* of 1996 authorized Public Housing Authorities to request criminal conviction information as part of the screening process for housing or determining eviction (Women’s Prison Association, 2003; The Council of State Governments Justice Center, n.d., as cited in, The Sentencing Project, 2012, p. 3). Individuals with a drug-related or violent crime, regardless of the amount of time that has passed since the offense, can be, and often are, denied public, Section 8, and other federally assisted housing by Public Housing Authorities (The Sentencing Project, 2012, p. 3; The Annie E. Casey Foundation, 2016, p. 4). Regarding financial resources, gaps in employment history due to incarceration combined with a lower level of

educational attainment hinder formerly-incarcerated parents' ability to find jobs that are sufficient to support their families (Coley & Barton, 2006). In summary, the disenfranchisement and risk factors typically experienced by persons who become involved with the criminal justice system only multiply upon release as the barriers to successful re-entry into the community are manifold and compounding.

A growing body of research shows that the most effective approach to reducing recidivism consists of multiple programs that are tailored to the unique risk factors and needs of each person (e.g. The National Reentry Resource Center, 2017, p. 6; Byrne, 2010). Covington and Bloom (2006) repeatedly emphasize the improved outcomes of a criminal justice system that fundamentally and tangibly acknowledges and responds to the differences between male and female offenders (p. 12). Moreover, they and others contend that "it is essential that providers ground theory and practice in a multi-dimensional perspective" (Covington & Bloom, 2006, p. 11; Byrne, 2010). A mother giving birth while in prison presents a unique opportunity for this kind of intervention in that it demands the collaboration of multiple systems – healthcare, criminal justice, mental health care, and social services. A report published by the Prison Policy Initiative, a non-profit organization devoted to research and advocacy, makes several pertinent recommendations for criminal justice reform. The first, is that the response to the female offender must shift from the "criminalization of women's survival behaviors" to effective ways of treating the underlying issues – trauma, substance use disorders, and mental health – that precipitate their criminal justice involvement (Bloom & Covington, 2008, p. 26; Sawyer, 2018). A trauma-informed and prison alternative approach that acknowledges the victimization of most offenders is advocated for as prison environments typically further exacerbate these underlying issues (Sawyer, 2018). While a detailed argument could be made for the necessity of myriad

program components for this population (e.g. substance abuse treatment), the scope of this paper is to outline clinical interventions rooted in theory and research to support the mother-infant relationship in a way that optimizes sustainable positive outcomes.

Minding the Baby

In 2002, a program was developed by Yale University involving an interdisciplinary collaboration of the Yale Child Study Center, Yale School of Nursing, Fair Haven Community Health Center, and Cornell Scott Hill Health Center that provides an excellent example of what a community-based intervention for incarcerated mothers may look like (Slade et al., 2005; Minding the Baby, n.d.). Minding the Baby (MTB) is an interdisciplinary, mentalization-based home visiting program that is grounded in attachment theory and seeks to enhance the relationship of high-risk mother-infant dyads (Minding the Baby, n.d.). MTB conceptualizes “high-risk” as being the cumulative effects of “chronic poverty, social disadvantage, and family dissolution,” acknowledging that these factors are “frequently associated with elevated rates of trauma, abandonment, and severe psychopathology,” which, as noted previously, are all correlated with, and oftentimes contributors to, criminal justice system involvement for many incarcerated women (Slade, 2006, p. 653; van IJzendoorn et al., 1999; Deklyen & Greenberg, 2008, as cited in Byrne et al., 2010). MTB aims to reach parents that are unable to effectively use community or school-based supportive programs due to complex bio-psycho-social needs by intervening via intensive home visiting (Minding the Baby, n.d.). A pediatric nurse practitioner and licensed clinical social worker visit the family one to two times per week beginning in the late second or early third trimester of pregnancy and concluding during the child’s second year of life (Minding the Baby, n.d.). MTB both acknowledges and addresses very real environmental factors while sharply focusing on providing important clinical services to mother-infants dyads

that would face substantial barriers to receiving these services elsewhere.

Currently, a National Institute of Health study is underway to test the efficacy of the program over the course of five years (Minding the Baby, n.d.). Data from the pilot phase of the work in 2002 on 61 intervention families and 45 control families shows numerous positive outcomes, including lower rates of child protection referrals, lower rates of rapid subsequent childbearing, and higher rates of on-time pediatric immunization (Minding the Baby, n.d.). Also, the study showed that “all intervention infants were more likely to be securely attached and less likely to be disorganized in relation to attachment at 1 year of age” (Sadler, Slade, Close, Webb, Simpson, Fennie, & Mayes, 2013, p. 391). Furthermore, results revealed that high-risk mothers’ capacity to reflect on their child’s experience as well as their own experience improved over the course of the intervention (Sadler et al., 2013, p. 391). These results are notable in light of Byrne and colleague’s study (2010) referenced earlier showing that mothers participating in prison nursery programming were less likely to maintain secure attachment upon release into the community than their counterparts who remained in the prison nursery environment for at least a year. MTB was acknowledged as an “evidence-based early childhood home visiting service delivery model” by the Home Visiting Evidence of Effectiveness (HomVEE) review in September of 2014 (Minding the Baby, n.d.). HomVEE was developed by the Department of Health and Human Services to provide “an assessment of the evidence of effectiveness for home visiting program models” that target families with children up to five years old (U.S. Department of Health & Human Services, n.d., para. 1). While mothers who give birth while incarcerated may not be sanctioned to live in their own homes, the interventions used in this program could be implemented in a community-based residential setting as an alternative to incarceration or as a preventative measure that addresses many factors contributing to women’s risk of involvement in

the criminal justice system in the first place.

Clinical Interventions

Minding the Baby began with several clinical assumptions. The first was that reflective capacities are likely to be compromised if early relationships were “characterized by attachment disruption and trauma;” therefore, the development of reflective capacities in the women they served would be vitally important (Slade et al., 2005; see Fonagy et al., 2002 for a review of related research). Similarly, they contended that “addressing the deficits and defenses that had led to such disrupted functioning would be vital to the development of healthy mother-child relationships” (Slade et al., 2005). The second assumption was that containment and regulation when working with infants must take place at both a mental and physical level because the “child comes to know their body through the hands of the mother” (Slade et al., 2005). Thus, the program is intentional about fostering the mothers’ confidence first in knowing and responding to the physical bodies of their babies and then, with time, the mental states of their babies (Slade et al., 2005). Additionally, as Slade and colleagues (2005) note, the core of infant-parent psychotherapy is the conceptualization of disruption in a mother-infant dyad as an indicator that the “mother’s capacity to represent the baby in a coherent and positive way” has been compromised (p. 4). They go on to illustrate that “unmetabolized and unintegrated affects stemming from [the mother’s] own early and usually traumatic relationship experiences can distort her representation of her baby (Slade et al., 2005, p. 4). Thus, the goal is to “disentangle” the affect related to the trauma from affect related to the relationship with the baby (Slade et al., 2005, p. 4). MTB contends that the relationship between the mother and the clinician is the vehicle of change as it optimally provides the mother with an experience of being heard and valued in ways that previous caregiving relationships did not afford her, which consecutively

strengthens her ability to know, tolerate, and regulate her baby (Slade et al., 2005). The benefits of this relationship combined with the health expertise of nurses and practical supports provided by the interdisciplinary collaboration of the program empower mothers to surmount environmental stressors (e.g. completing an educational program, gaining employment, waiting to have another child) in ways that improve long-term outcomes for both themselves and their children (Slade et al., 2005). The very real ramifications of environmental stressors that disadvantaged families face demand a flexible and collaborative treatment team that can support them concurrently on many levels for sustainable effectiveness (Lieberman, 2003, as cited in Slade et al., 2005). Minding the Baby is an example of various systems and disciplines – healthcare, mental health care, and social services – collaborating in a way that both extends far enough to reach the most disadvantaged and efficiently produces a myriad of longitudinal outcomes. Using this example, various components of MTB will be reviewed with consideration for appropriateness of fit in use with incarcerated women and their infants.

Reflective functioning. There are a variety of ways in which a clinician can support a mother-infant dyad, but the literature strongly advocates for a focus on enhancing reflective parenting skills (also described as reflective functioning and mentalizing; e.g. Siegel, 1999; Fonagy et al., 2002; Slade, 2006, p. 647). For decades, “mothers’ attunement to their own and their babies’ subjective experiences” has been central to clinical work and theorizing regarding attachment (e.g. Fraiberg, 1980; Ainsworth et al., 1978; Hoffman, Marvin, Cooper & Powell, 2006). Therefore, it is unsurprising that enhancing reflective functioning is “intrinsic” to Minding the Baby’s clinical model (Minding the Baby, n.d.). Slade and colleagues (2005) draw on the work of Fonagy and others (2002) as they articulately point out that “experiences that can be known and understood, held in mind without defensive distortion, can be integrated and

contained” (p. 2). Minding the Baby’s webpage (n.d.) summarizes the vital importance of this skill in parenting by stating:

[reflective functioning] allows the mother to regulate her baby’s states of arousal and affective experience, and is at the heart of a mother’s ability to insure her child’s physical health and safety, setting the stage for the development of secure, reciprocal, and flexible attachment relationships. (Minding the Baby, n.d.)

There are two facets to consider when conceptualizing the development of reflective capacities in high-risk parents. The first is the parent’s own history and resulting attachment template because this will determine the content that arises when the parent is attempting to engage in reflective parenting. The second is the practical question of methods through which such an abstract and intuitive concept can be taught. In many ways, these two considerations are deeply intertwined.

Attending to the mother’s history. Slade (2006) observes that women who are considered to be high-risk typically, due to their own traumatic experiences and absence of reliable caregivers, have a compromised ability to parent reflectively (p. 653). Bloom and Covington (2008) note that Posttraumatic Stress Disorder (PTSD) appears to be one of the most common mental health problems among incarcerated women, alongside substance abuse and depression (p. 2). Liotti (2004) explains the difficulty of parenting among the backdrop of one’s own traumatic history by noting that requests for attachment from one’s children can prompt the mother’s own unresolved traumatic memories to surface (p. 477). If this trauma is not resolved, it can directly affect the emotional experience of the mother (Tucker, Frishkoff, & Luu, 2008, as cited in, Siegel, 1999). Liotti (2004) contends that, even as adults, the attachment system is activated during and after experiences of fear and psychological or physical pain (Bowlby, 1979,

p. 129, as cited in Liotti, 2004, p. 477). He provides the example of a parent becoming dysregulated at her child's cry and displaying "unwitting, abrupt manifestations of alarm and/or anger" that interfere with her instinct to care for her child (Liotti, 2004, p. 477). If left untreated, unresolved trauma can "permit dysfunction to continue across the generations within the devastating effects of disorganized attachment" (Siegel, 1999, p. 137). Slade (2006) makes the powerful observation that most parents are faltering in areas where they themselves have not been held or heard (p. 648). As Siegel (1999) summarizes, "If we can help those with unresolved trauma heal, then we can alter the cycle of intergenerational transmission of relationship disturbances – a cycle that produces and perpetuates devastating emotional suffering. (Siegel, 1999, p. 141). Slade (2006) contends that a vital component of any program developing parenting skills is holding the parent in mind (p. 647). In other words, the clinician must hold the mother in mind while teaching her how to hold her baby in mind.

Teaching reflective parenting. In MTB, reflective parenting is taught through both the therapeutic relationship and practical guiding strategies. The program, being rooted in attachment theory and a psychoanalytic perspective, coalesced around the stance that

it is the mother's relationship with the home visitors that provides a variety of levels of presence and support that are crucial to mothers developing reflective capacities; the clinician's holding, containment, attunement, and acceptance are crucial to the emergence of coherent representations of self and other, personal autonomy, and a sense of a positively felt, authentic self. Change in the mother's (and family's) sense of effectiveness and competence in relating to a variety of relationships and community systems emerge as a function of mutative relationships with a caring other. This is the therapeutic engine that drives the intervention, and that will hopefully promote maternal

sensitivity and understanding across a range of domains. (Minding the Baby, n.d.)

While original internal working models of attachment are established in infancy, some literature supports the idea that attachment templates can become more secure in adulthood; studies often refer to an “earned” secure attachment status that develops out of an insecure attachment template within the context of a significant relationship (e.g. Doidge, 2007, as cited in, Siegel, 1999; Pearlman & Courtois, 2005, pp. 451-452; Schore, 2003). Siegel (1999) proposes that a healing relationship significant enough to alter attachment templates must involve several fundamental elements:

contingent, collaborative communication; psychobiological state attunement; mutually shared interactions that involve the amplification of positive affective states and the reduction of negative ones; reflection on mental states; and the ensuing development of mental models of security that enable emotional modulation and positive expectancies for future interactions. (p. 143)

An example of how this kind of relationship would manifest itself within the context of clinical treatment can be found in the relationship between the home visiting clinicians and the mothers of Minding the Baby. Sadler and colleagues (2006) explain that within this relationship, the mothers

experience themselves as *meaningful* in the eyes of the home visitors; the experience of being held in mind as a coherent, intentional person who is trying to do her best allows mothers to start experiencing themselves and the baby in the same way. (p. 378).

Though more research is needed to determine exactly what “factors and mechanisms” the mind uses to create a coherent narrative over time despite an insecure attachment history, there is, at the very least, anecdotal evidence that a process exists to “break the transgenerational passage of

insecure attachment patterns” (Dozier et al., 2008, as cited in, Siegel, 1999, p. 120).

In addition to promoting a secure attachment within the therapeutic relationship, Slade (2006) identifies five strategies that she and her colleagues at the Yale Child Study Center view as “essential to developing a reflective stance in parents.” The first is “modeling reflectiveness” in which clinicians continuously strive to illustrate a child’s mental states and intentions to the parent (Slade, 2006, p. 645). Oftentimes, parents focus on the child’s external state, that is the child’s behavior (Slade, 2006, p. 645). Home workers do not seek to contradict the parent’s perception but rather make apparent the child’s thoughts and feelings in a way that is “sensible” to the parent (Slade, 2006, p. 645). This process of wondering, linking behavior to feelings, and linking the parent’s mental state to that of her child’s (Slade, 2006, pp. 645-646) provides a new framework for understanding the parenting relationship in a reflective manner. The second strategy Slade (2006) proposes is “facilitating wondering,” which involves implementing an attitude of curiosity toward the child’s experience framed by the recognition that the child’s experience is separate from the parent’s (p. 646). These moments provide opportunities for the clinician to provide psychoeducation on development (Slade, 2006, p. 646). The third strategy Slade (2006) mentions is “eliciting affect as a means to mentalization” (p. 646). Slade (2006) notes that change happens when therapeutic evaluation can occur while the parent is experiencing strong emotions; thus, it is common for the most “successful parent-infant interventions” to arise in-the-moment (p. 646). Making meaning of these moments in which the parent is dysregulated promotes reflection and greater mentalizing capacities (Slade, 2006, p. 647). Slade elaborates by explaining that

the reflective function... is engaged when the affects intrinsic to the interaction are generated and contained in a way that the mother can safely envision her child’s and her

own mental states, presumably in a new relationship to each other. In essence, she begins to symbolize the relationship in more complex and flexible ways, which inherently changes the way she experiences the relationship. (Slade, 2006, p. 647)

The fourth strategy Slade (2006) describes is “holding the parent in mind,” which she notes varies based on the parent’s capacity to hold their child in mind (p. 647). Slade (2006) goes on to explain that this capacity is largely dependent on the parent’s own feelings and desires, which result from their own childhood experiences (p. 647). The home worker seeks to “hold” these experiences with the mother in a way that makes them tolerable and understood (Slade, 2006, p. 647). Slade (2006) summarizes the importance of this aspect of intervention by saying, “A parent’s capacity to – in Selma Fraiberg’s (1980) words – ‘hear her baby’s cry’ is within most clinical situations contingent on the clinician’s capacity to hear the mother’s cry” (p. 647). Finally, Slade’s (2006) fifth strategy is “working at a level the parent can manage” (p. 648). For some parents, the child’s internal experience is scary, overwhelming, and perhaps a reflection of their own unbearable internal experience (Slade, 2006, p. 647). A common thread among each of these strategies is the necessity of frequent in-person contact with the mother-infant dyad, ideally in an environment that they carry out their daily lives in, which is typically found in residential or frequent home visiting programs. Moreover, access to spontaneous moments is crucial in work with mother-infant psychotherapy (Slade, 2006; Slate et al., 2005).

Value of immediacy. There are few experiences as intense as raising one’s first child within the context of intense environmental stressors, such as poverty or violence. Siegel (1999) notes, “Implicit elements from early life experiences are quickly activated in intense emotional relationships, such as those with children and spouses” (p. 119). He goes on to explain:

There is a direct connection between how past experiences have shaped implicit memory

and how they are reactivated in the setting of being with a child. If parents do not recognize this link, then they are at risk of reenacting, without conscious awareness, learned behaviors and emotional responses that will dominate their actions and create their children's attachment experiences. If these implicit memories are of healthy forms of relating, then the outcome will be a secure attachment. If instead the parents had less than optimal experiences, without self-reflective work they may be at risk of passing on either imitated patterns or adaptations to these relationships, which will keep their children from experiencing a dependable emotional closeness which secure attachments require. (Siegel, 1999, pp. 132-133)

Therapeutic work for individuals and families who have experienced unresolved trauma and loss demands an understanding of "rapid shifts in [mental] states and their connection to patterns of relationships from the past" (Siegel, 1999, p. 141). By definition, implicit memory and unconscious awareness are difficult to identify within one's own self. Working with a supportive other in the context of a therapeutic relationship can facilitate this process whereby increasing the parent's "capacity to tolerate and regulate her own internal, affective experience," which "allows her to tolerate and regulate these experiences in her child" (Slade, 2006, p. 641). The value of immediacy is well-documented in many psychotherapeutic interventions (e.g. Slade, 2006, p. 646; Fraiberg, 1980) and is an important consideration when considering potential effective community-based alternatives for women who give birth while incarcerated.

Context. When planning to serve any population, it is important to consider context. For populations that are considered to be "at-risk," it would be imprudent to ignore the compounding and interwoven effects of poverty, systemic disadvantage, and family disruption as they significantly impact the development of both infants and parents and frequently spontaneously

interject in the course of treatment (Shonkoff & Phillips, 2000, as cited in Sadler et al., 2013, p. 391; Slade et al., 2005). Slade (2006), co-director of MTB, contends that the women participating in their program, many of whom are trapped within complex life circumstances, including limited resources, unstable support networks, and dangerous environments,

come to early parenthood facing an enormous number of challenges and often find it very difficult to provide sustaining and secure environments for their children. They struggle just as powerfully to right their own lives and to find meaning in sustenance in intimate relationships and in work. (p. 653)

As outlined previously in this paper, this observation is profoundly descriptive of women who have been incarcerated for whom the effects of poverty are compounded by the effects of the criminal justice system (e.g. becoming ineligible to apply for sufficient employment, denied student loans, disqualified to vote). Due to the complexity of challenges this population faces, the traditional model of receiving mental and physical health services – scheduling an appointment with the appropriate provider, arranging transportation, finding reliable childcare, and paying the bill – must be creatively adjusted to allow opportunity for effectiveness and efficiency in treatment.

Moreover, it is well documented that we can trace the majority of women's criminal behavior back to roots consisting of interpersonal trauma (e.g. Pollock, 1998, as cited in Bloom & Covington, 2008, p. 8). Bloom and Covington (2008) assert that women are unlikely to benefit from programming that occurs in-custody and post-release unless it accounts for this history. An alternative to incarceration for mothers, built around a support system of professionals with experience in treating and healing this kind of trauma, is a viable option. Thus, it makes logical and theoretical sense that any program seeking to effectively overcome complex stressors that

contribute to poor outcomes for mothers and infants would seek to support the mother, the infant, and the mother-infant relationship in conjunction with other service providers, while simultaneously attending to the family's environment and the way in which they interact with it. A program designed as a community-based alternative for incarcerated women and their newborns would by its very nature demand such a collaboration between the criminal justice system, the healthcare system, and the social service system.

Conclusion

The information that research studies and practice have brought forth regarding incarcerated women is profound. The majority of incarcerated women have experienced a significant amount of trauma, mental illness, and substance use which intersected with social policies in ways that disproportionately increased the likelihood they would be caught up in the criminal justice system when compared to men. Justice is a complex and difficult construct to gauge when considering the various injustices that precipitate women's involvement in the criminal justice system. It may never be feasible to fully assess and provide empirical evidence for the ramifications of these experiences; however, research is beginning to document the detrimental cost of not shifting the paradigm of the United States' criminal justice system from being centered on crime and punishment to a fiscally and socially responsible model that views crime as the outcome of other precipitating factors that need to be attended to during the individual's time in the criminal justice system. In order to successfully implement such a system, interventions must effectively account for the complexity of the pathways that brought women to it in the first place. Attachment theory provides one way of clinically conceptualizing the experiences of women who are incarcerated and anticipating challenges they will have both in relationships with others and in motherhood. Moreover, attachment theory and research

provide compelling reasons to critically examine current responses to women who give birth while incarcerated and can be used to guide innovative program development for high-risk mothers, such as *Minding the Baby*.

Continued research regarding attachment and program effectiveness of currently existing community-based alternatives to incarceration for mothers and infants could further inform clinical interventions with this population. It is also important to note that although this paper focuses primarily on incarcerated mothers and infants, continued research and clinical work in this area would be remiss to not also account for the experiences of incarcerated persons who are not parents, incarcerated fathers, and older children of incarcerated parents as these persons and experiences are interwoven and collaterally impact each other.

The Second Chance Act passed in 2008 was the result of a bipartisan conversation acknowledging that paving a path from incarceration to re-entry in the community was a sensible objective that benefited the nation as a whole “because anything short of that objective compromises public safety, wastes taxpayer dollars, and undermines the well-being and stability of communities” (The National Reentry Resource Center, 2017, p. 2). Since the nation began focusing more policy attention and allocating resources toward reducing the prison population in 2008 with *The Second Chance Act*, the women’s prison population has grown outpacing men’s, grown while men’s declined, or declined proportionally less than men’s in seventy-percent of states, according to the Prison Policy Initiative (Sawyer, 2018). While decreasing the number of men incarcerated is certainly a productive step toward the achieving the overarching goal of the *Second Chance Act*, it’s benefits are certainly mitigated by the increasing number of women incarcerated. It is time to start allocating attention and resources toward incarcerated women. A program providing clinical services to incarcerated women and their babies in the community by

its very nature provides re-entry support, protects public safety in that it reduces recidivism rates, uses taxpayer dollars more efficiently than the current system, and enhances the well-being and stability of communities by fortifying families through a bi-generational, multisystemic approach. When considering the purpose of and desired outcomes from a criminal justice system, it stands to reason that we have strayed from the purpose of a such a system in a civilized society and are falling immorally short of the potential redemption that could be brought about through such a process if implemented in a way that is responsive and attuned to the complexity of the human lives who find themselves within it.

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